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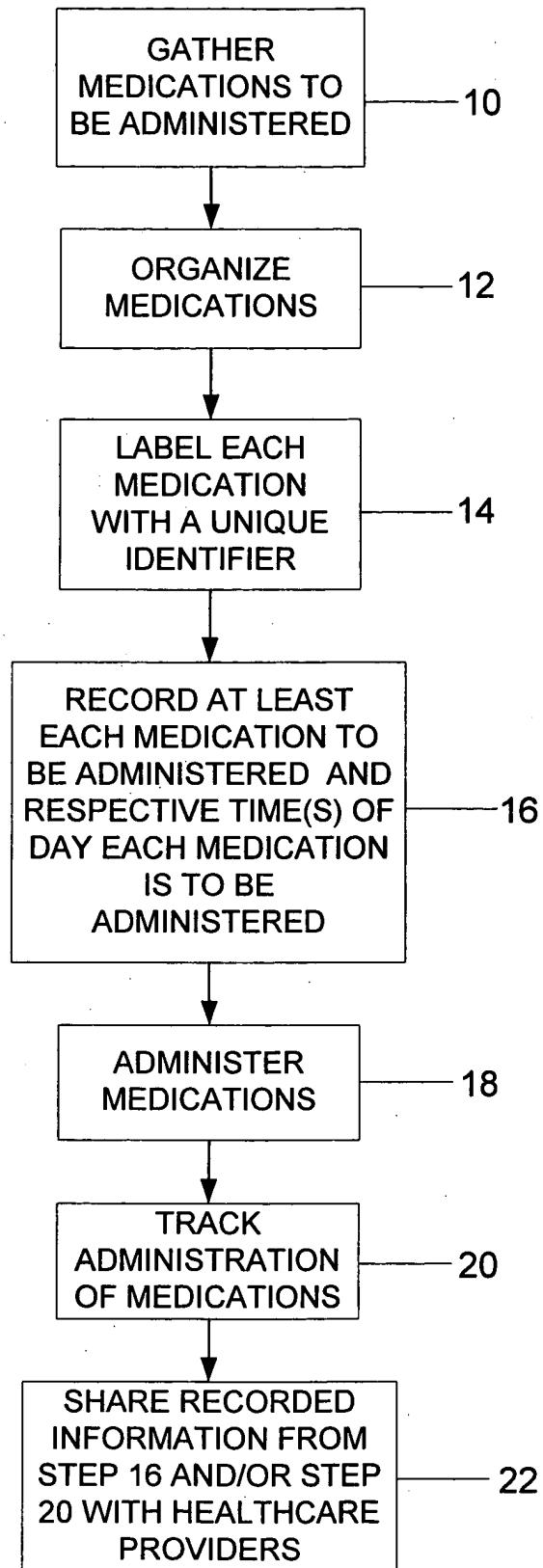


Fig. 1

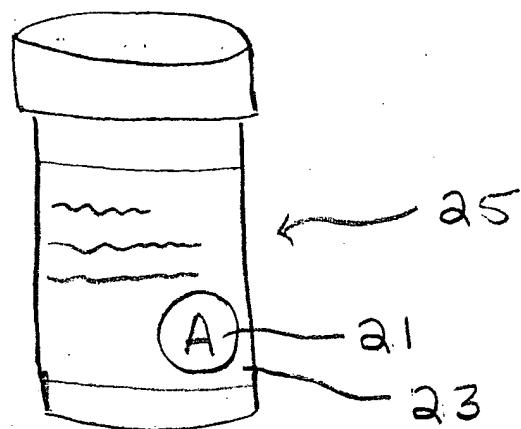


FIG. 2

Medication	Frequency				
	a.m.	noon	p.m.	bed	as needed
Medication 1	X		X		
Medication 2					X
Medication 3	X	X	X	X	
Medication 4		X			

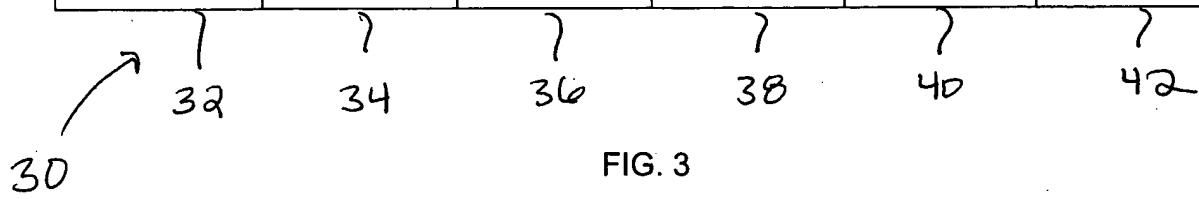
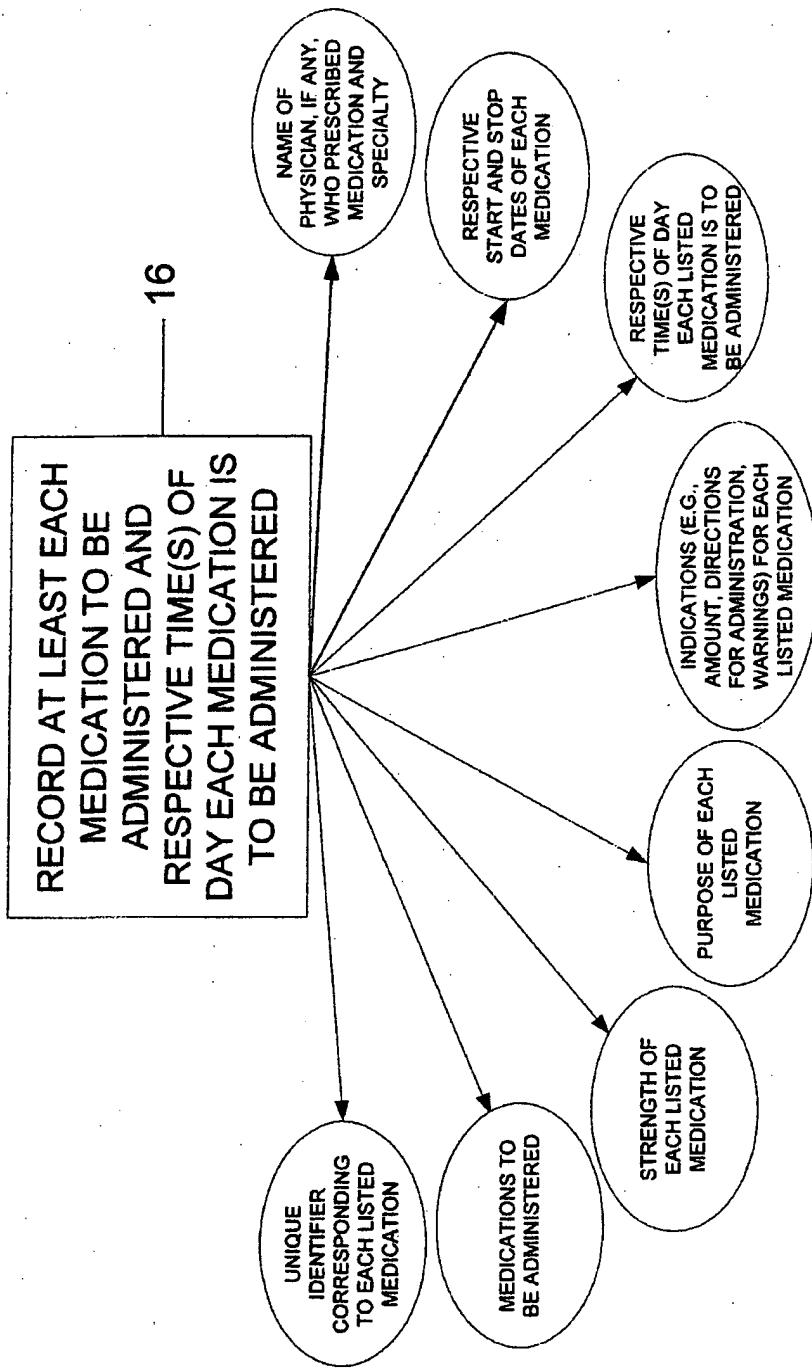


FIG. 3

Fig. 4



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2

七

name _____
allergic to _____

65

JULY	week day:	am	noon	pm	bed	as needed	notes:
	1	V	V	V	V		
	2						
	3						
	4						
	5						
	6						
	7						
	8						
	9						
	10						
	11						
	12						
	13						
	14						
	15						
	16						
	17						
	18						
	19						
	20						
	21						
	22						
	23						
	24						
	25						
	26						
	27						
	28						
	29						
	30						
	31						

66 67 68 69 70 71 72 73

AUG	week day:	am	noon	pm	bed	as needed	notes:
	1						
	2						
	3						
	4						
	5						
	6						
	7						
	8						
	9						
	10						
	11						
	12						
	13						
	14						
	15						
	16						
	17						
	18						
	19						
	20						
	21						
	22						
	23						
	24						
	25						
	26						
	27						
	28						
	29						
	30						
	31						

FIG. 6

SEPT	week day:	am	noon	pm	bed	as needed	notes:
	1						
	2						
	3						
	4						
	5						
	6						
	7						
	8						
	9						
	10						
	11						
	12						
	13						
	14						
	15						
	16						
	17						
	18						
	19						
	20						
	21						
	22						
	23						
	24						
	25						
	26						
	27						
	28						
	29						
	30						
	31						

66 67 68 69 70 71 72 73

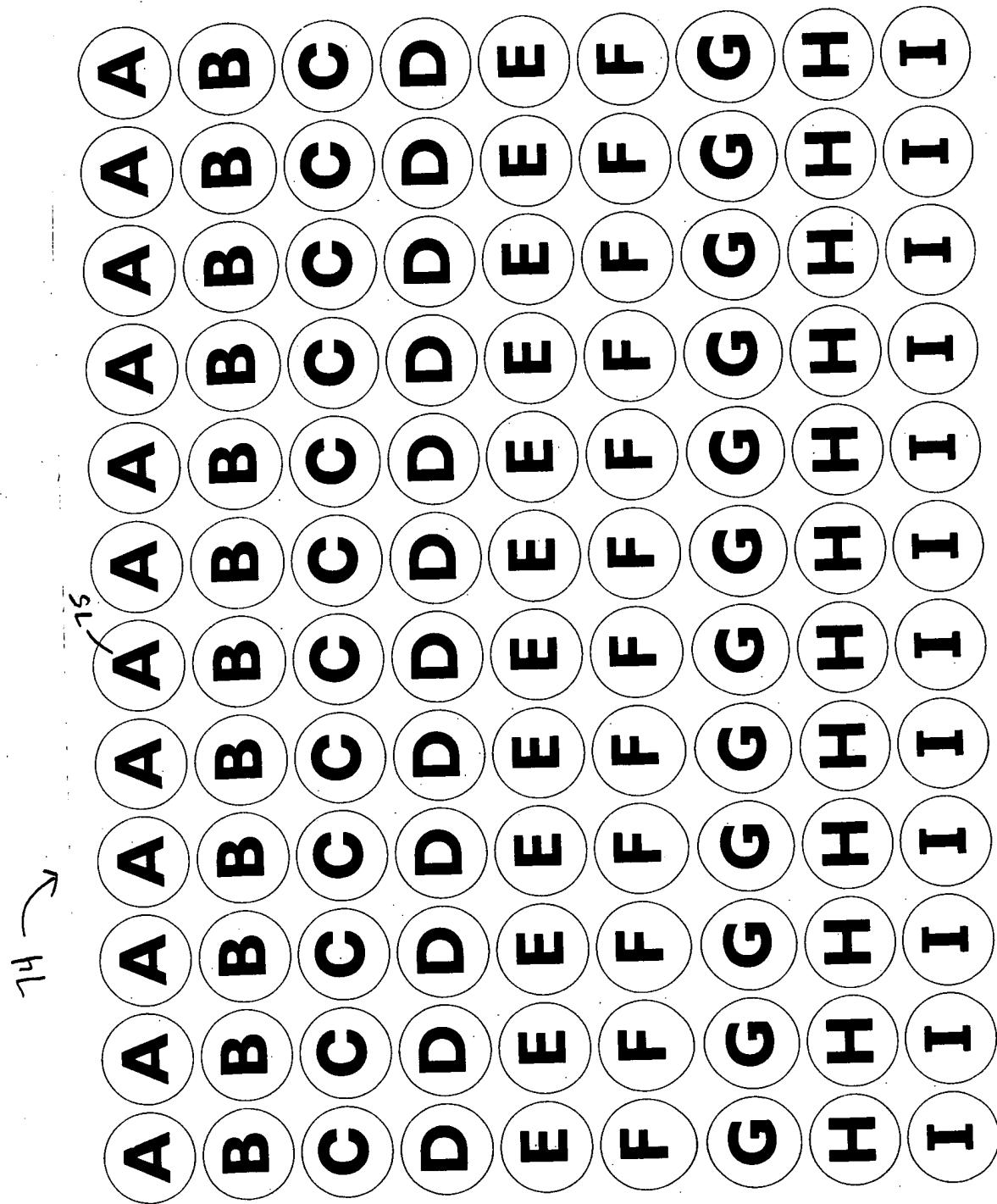


Fig. 7 (a)

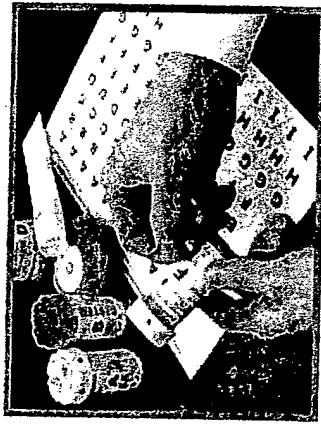
FIG. 7(b)

JAN week day:	am	noon	pm	bed	as needed	notes:
	1					
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						

FEB week day:	am	noon	pm	bed	as needed	notes:
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29 (Sun cont.)						

FIG. 7(c)

INSTRUCTIONS



1. label...

- Gather all your prescription and over-the-counter medications. (Include herbal products, dietary supplements, pain relievers, eye drops, nose sprays, cough syrups, etc.)

- Under the red tab below, locate the **A-Z labels**. Place a different letter of the alphabet on each medication container.

If you refill a prescription, use the same letter of the alphabet on the new container.



2. list...

Under the yellow tab below, locate a blank **medication chart**. A sample medication chart is visible when you lift the tab.

Using the **sample medication chart** as your guide, begin to list your medications. Start with medication **A**, then **B**, etc.

Review your medication chart with your physician or pharmacist on each visit.



3. take safely.

Every time you take your medications:

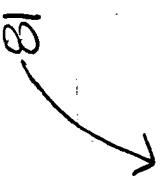
- Using your **medication chart** and your **A-Z labels** as guides, remove only those medications you need for that time of day.
- Read the directions and warnings on your chart before you take each medication.
- After you take each medication, place that container away from the others.
- Under the blue tab, locate the **daily checklist** for the current month. Indicate under the correct day and time that your medications were taken.

80

Fig. 7(d)

healthcare contacts

name
8a



Dr.	specialty	Dr.	specialty	Dr.	specialty
phone	phone	phone	phone	phone	phone
fax	e-mail	fax	e-mail	fax	e-mail
address		address		address	
Dr.	specialty	Dr.	specialty	Dr.	specialty
phone	phone	phone	phone	phone	phone
fax	e-mail	fax	e-mail	fax	e-mail
address		address		address	
Dr.	specialty	Dr.	specialty	Dr.	specialty
phone	phone	phone	phone	phone	phone
fax	e-mail	fax	e-mail	fax	e-mail
address		address		address	
Dr.	specialty	Dr.	specialty	Dr.	specialty
phone	phone	phone	phone	phone	phone
fax	e-mail	fax	e-mail	fax	e-mail
address		address		address	

FIG. 7(e)

emergency contacts

name _____
date of birth _____

Emergency #	911	Hospital name	Insurance Co.
Fire Department #		phone	policy #
Police Department #		fax	I.D. #
Ambulance Service #		address	phone
National Poison Center	1-800-222-1222		address
Emergency contact		Clinic name	Insurance Co.
relationship		phone	policy #
phone (h)	(w)	fax	I.D. #
cell phone		address	phone
e-mail			address
Emergency contact		ORGAN/DONOR TISSUE CARD:	
relationship	witness	phone	MEDICAL CONDITIONS
phone (h)	(w)	Phone	<input type="checkbox"/> infectious disease <input type="checkbox"/> asthma <input type="checkbox"/> cancer <input type="checkbox"/> depression <input type="checkbox"/> diabetes <input type="checkbox"/> liver disease <input type="checkbox"/> emphysema <input type="checkbox"/> heart disease <input type="checkbox"/> hypertension
cell phone		date card was signed	
e-mail		location of card	
POWER OF ATTORNEY FOR HEALTHCARE:			
name	attorney	Living Will:	
phone	phone	date of will	location of will
date of document			
location of document			

FIG. 7(f)

83

name _____
date of birth _____

name _____
date of birth _____

IN CASE OF EMERGENCY, PLEASE CONTACT

name _____

relationship _____ cell (C) _____

home (C) _____ work (C) _____

city _____ state _____ zip _____

INSURANCE INFORMATION

insurance co. _____

policy holder _____

member ID# _____

group ID# _____

phone _____ fax _____

Medicare yes no

PRESCRIPTIONS AND
OVER-THE-COUNTER MEDICATIONS

medication _____

dose _____

MEDICAL CONDITIONS

asthma

cancer

depression

diabetes

emphysema

heart disease

hypertension

infectious disease

kidney disease

liver disease

ALLERGIES

medications: _____

food: _____

other: _____

Vital Information WALLET CARD

PERSONAL INFORMATION

name _____

address _____

city _____

state _____

zip _____

home (C) _____

work (C) _____

birthdate _____ / _____ / _____

SS # _____ - _____ - _____

blood pressure _____

□ normal

□ high

□ low

male

female

blood type _____

organ/tissue donor yes no

donor card location _____

living will yes no

living will location _____

Do you need help
organizing your medications?

Ask your Kerr Drug pharmacist about
my medmanager

KERR DRUG

1-800-000-0000
www.kerrdrug.com

Vital Information Wallet Card
brought to you by
GLAXOSMITH-KLINE

✓

90

✓

90

✓

90

✓

90

✓

90

190'

FIG. 7 (g)

date 1/16/04

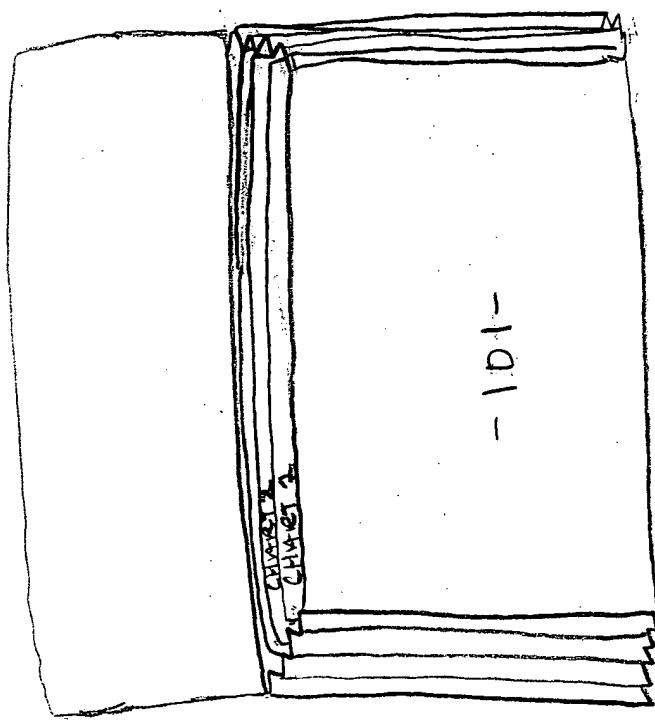
name John Doe
allergic to penicillin

92 93

A-Z letter	medication / strength	purpose	amount / directions / warnings	Time of Day			start date	stop date	physician
				am	noon	pm			
A	hydralazine HCl 25 mg	high blood pressure	1 tablet twice a day		X	X	4/8/02		Kline (cardiologist)
B	warfarin 5 mg	blood thinner	1 tablet once a day (limit vitamin K foods, such as kale, spinach, broccoli)		X		5/20/02		Kline (cardiologist)
C	timolol 0.25%	glaucoma	1 drop in each eye twice a day	X	X		12/10/93		Carter (ophthalmologist)
D	hydrocodone-CP	strength	1 teaspoonful (5 ml) every four hours for five days		X	X			
E	promethazine HCl 25 mg	nausea and vomiting	1 in rectum every six hours as needed (keep in refrigerator)			X			Anderson (internist)
F	calcium 600 mg	bone strength	1 tablet three times a day		X	X	2/1/04		Anderson (internist)
G	St. John's wort	depression	1 capsule three times a day		X	X	3/18/04		
H	albuterol	shortness of breath	2 inhalations every four to six hours as needed (avoid caffeine)			X	4/24/04		Robinson (allergist)
I	zolpidem 10 mg	insomnia	1 tablet at bedtime for sleep as needed (no alcohol)			X	5/20/04		Martin (psychiatrist)
J	ciprofloxacin 500 mg	infection	1 tablet twice a day (on an empty stomach)	X	X		5/25/04	5/31/04	Smith (urologist)

Fig. 7(h)

FIG. 7(i)



100

FIG. 7(j)

- 200 -



FIG. 7(k)